		** MEDICA ** SERVICES	45	10107110	FORM APP OMB NO. 093	
STATEMEN	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDE SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLI A. BUILDING	E CONSTRUC	(X3) DATE SURVE COMPLETED	ΞΥ
		445130	B. WING		08/17/20	140
	PROVIDER OR SUPPLIER EALTHCARE, SPARTA		34 6	ET ADDRESS, CITY, STATE, ZIP CODE GRACEY ST ARTA, TN 38583	00/1//20	<u>,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,</u>
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHOT CROSS-REFERENCED TO THE APPROFICIENCY)	DULD BE CO	(X5) MPLETION DATE
K 050 SS=D	Fire drills are held a varying conditions. The staff is familiar that drills are part o Responsibility for plassigned only to co qualified to exercise conducted between	AFETY CODE STANDARD at unexpected times under at least quarterly on each shift. with procedures and is aware f established routine. I anning and conducting drills is impetent persons who are a leadership. Where drills are 9 PM and 6 AM a coded or be used instead of audible	K 050	K 050 Fire drills On 9-6-10 all staff were inservice Administrator on the location of the stations and the proper fire process Maintenance Director will perform as specified in the state regulation shift per month) and also on new orientation. Evaluations of the dri complied and any issues that arise addressed immediately following Completed 9-6-10	d by the he pull dures. m fire drills ns (one per hire lls will be e will be	ı-6-10
K 052 SS=D	Based on observation facility failed the fire facility failed the fire The findings include Observation during AM, revealed the state activate the fire alarm Protection Association This finding was ack Administrator and verification and the NFPA 101 LIFE SAFA fire alarm system installed, tested, and with NFPA 70 Nation 72. The system has	the fire drill on 8/17/10 at 9:58 aff did not immediately m system. National Fire on (NFPA) 101, 19.7.2.3 mowledged by the prified by the Director of exit conference on 8/17/10. FETY CODE STANDARD required for life safety is I maintained in accordance all Electrical Code and NFPA an approved maintenance complying with applicable	K 052	The Maintenance Director will me compliance of fire drills through the assurance process. The Maintenar will monitor all drills monthly to all staff are aware of the procedur Findings will be reported the Quant Assurance Committee which is much following people: Medical Director of Nursing Information Manager, Social Serv Director, Falls Prevention Nurse, Rehab Coordinator and Wound Carthe monitor will be continued as by the Maintenance Director or as by the Quality Assurance Commit	he quality nce Director evaluate if es. lity ade up of ector, g, Health ices Facility are Nurse, determined idirected	
BORATORY	DIRECTOR'S OR PROVIDE	R/SUPPLIER REPRESENTATIVE'S SIGNA	ATURE	TITLE	(X6) DA	ATE
1/2	Star	<u> </u>	Adn:	nistrator	9-3.10	
ny deficiency	statement ending with an	asterisk (*) denotes a deficiency which			ling it is determined	I that

In deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that ther safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days allowing the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 ays following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued rogram participation.

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	TMENT OF HEALTE	AND HUMAN SERVICES & MEDIC/ SERVICES				APPROVEI . 0938-039	
STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDENSUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION 01 - MAIN BUILDING 01		(X3) DATE SURVEY COMPLETED	
		445130	B. WING		08/1	7/2010	
	PROVIDER OR SUPPLIER ALTHCARE, SPARTA		34	EET ADDRESS, CITY, STATE, ZIP CODE GRACEY ST PARTA, TN 38583	, , , ,		
(X4) ID PREFIX TAG	: (EACH DEFICIENCY	TEMENT OF DEFICIENCIES 'MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE	
K 052	Continued From pa		K 052	K 052 Pull Stations On 8-18-10 Maintenance moved 2 stations in the basement corridor of 54-inch rule. On 9-2-10 all other pstations in the facility were measured etermine if they complied with the other stations needed to be moved Completed 9-2-10	to met the pull ured to his rule - no	9-2-10	
K 054 SS=D	This STANDARD is not met as evidenced by: Based on observation it was determined the facility failed to maintain the fire alarm system. The findings include: Observation of the basement corridor on 8/17/10 at 10:15 AM, revealed the 2 pull stations were mounted above the 54-inch rule. National Fire Protection Association (NFPA) 72, 2-8.1 This finding was acknowledged by the Administrator and verified by the Director of Maintenance at the exit conference on 8/17/10. NFPA 101 LIFE SAFETY CODE STANDARD All required smoke detectors, including those activating door hold-open devices, are approved, maintained, inspected and tested in accordance with the manufacturer's specifications. 9.6.1.3 This STANDARD is not met as evidenced by: Based on observation it was determined the facility failed to maintain the smoke detectors. The findings include:		K 054	The Maintenance Director will mo compliance of pull stations throug quality assurance process. The Ma Director will monitor all pull stati monthly x 3 months to make sure not been moved. Findings will be the Quality Assurance Committee made up of the following people: I Director, Administrator, Director of Health Information Manager, Soci Director, Falls Prevention Nurse, I Rehab Coordinator and Wound Ca K 054 Smoke Detectors On 8-18-10 Maintenance moved the detector in station 3 dining room to compliance with NFPA rules. On 9 smoke detectors in the building we reviewed to verify that they meet thrule. Completed 9-2-10 The Maintenance Director will mosmoke detector placement through quality assurance process. The Maintenance Director will monitor all smoke demonthly x 3 months to make sure the compliance. Findings will be report Quality Assurance Committee which up of the following people: Medica	h the sintenance cons they have reported to which is Medical of Nursing, al Services Facility are Nurse. The smoke of the intenance tectors hey are in ted to the cons cons constant of the c	9-2-10	

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(NFPA) 72, 2-3.5.1

Observation of the station 3 dining room revealed

a smoke detector was in the direct path of an air

diffuser. National Fire Protection Association

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Administrator, Director of Nursing, Health

Director, Falls Prevention Nurse, Facility

Rehab Coordinator and Wound Care Nurse.

Information Manager, Social Services

AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILD	ING 01 - MAIN BUILDING 01	COMPLETED	
				08/17/2010		
	PROVIDER OR SUPPLIER ALTHCARE, SPARTA			TREET ADDRESS, CITY, STATE, ZIP CODE 34 GRACEY ST SPARTA, TN 38583		
(X4) ID PREFIX TAG	(EACH DEFICIENC	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIVE ACTION SHO (EACH CORRECTIVE ACTION SHO CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE COMPLÉTION	
K 054	Continued From page 2		K 05	4 K 64 Portable Fire Extinguisher	°s 9-6-10	
K 064 SS=E	Administrator and Maintenance at the NFPA 101 LIFE SA Portable fire exting health care occupa	acknowledged by the verified by the Director of exit conference on 8/17/10. AFETY CODE STANDARD uishers are provided in all incles in accordance with NFPA 10	K 064	On 8-18-10 the fire extinguisher in recreation office was mounted in a with NFPA requirements. On 8-18 fire extinguisher in the old boiler r moved to met the NFPA requirements 17-10 items that were blocking the extinguishers in the Health Information office and Maintenance shop were On 9-3-10 all portable fire extinguisher building were checked to make met the NFPA requirements of being properly hung and not blocked. Or all staff were inserviced by the Adi	ccordance 3-10 the room was ents. On 8- efire ation moved. ishers in esure they ng 19-6-10	
	Based observation	is not met as evidenced by: it was determined the facility ne fire extinguishers.		on making sure fire extinguishers a blocked. Completed 9-6-10		
	9:45 AM, revealed mounted on the wa Protection Associated Observation of the 9:50 AM, revealed mounted above the Observation of the the maintenance strevealed the fire exequipment. NFPA 1	recreation office on 8/17/10 at the fire extinguisher was not II as required. National Fire tion (NFPA) 10, 1.6.7 old boiler room on 8/17/10 at the fire extinguisher was 60-inch rule. NFPA 10, 1.6.10 the alth information office and top on 8/17/10 at 10:00 AM, tinguishers were blocked with		The Maintenance Director will more compliance of fire extinguishers the quality assurance process. The Main Director will review all areas of the monthly x 3 months to verify that p fire extinguishers are in proper located not blocked. Findings will be report Quality Assurance Committee whice up of the following people: Medical Administrator, Director of Nursing, Information Manager, Social Service Director, Falls Prevention Nurse, Fa	rough the intenance building ortable ations and reted to the th is made I Director, Health ces acility c Nurse. etermined lirected	
	Administrator and v Maintenance at the	erified by the Director of exit conference on 8/17/10. FETY CODE STANDARD	K 067			

	TOTAL OF THE SET	TARE HUMAN SERVICES		ri pi	ORM APPROVED
CENTE	RS FOR MEDICARE	& MEDIC/ SERVICES			3 NO. 0938-0391
	IT OF DEFICIENCIES OF CORRECTION	(X1) PROVIDE. USUPPLIER/CLIA IDENTIFICATION NUMBER:	A. BUILI	DING 01 - MAIN BUILDING 01	ATE SURVEY OMPLETED
		445130	B. WING	3	08/17/2010
NAME OF	PROVIDER OR SUPPLIER		:	STREET ADDRESS, CITY, STATE, ZIP CODE	90.11.2010
NHC HE	ALTHCARE, SPARTA			34 GRACEY ST SPARTA, TN 38583	
(X4) ID PREFIX TAG	(EACH DEFICIENC)	ATEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
K 067	Heating, ventilating with the provisions in accordance with specifications. 19 19.5.2,2 This STANDARD is Based on observation facility failed to main	, and air conditioning comply of section 9.2 and are installed the manufacturer's 9.5.2.1, 9.2, NFPA 90A, s not met as evidenced by: on it was determined the ntain the Heating, Ventilating.	K 06	conditioning On 8-18-10 the Maintenance Director rehu the exhaust fan vent cover. On 9-2-10 all vent covers in the facility were checked to make sure they were properly hung. Completed on 9-2-10. The Maintenance Director will monitor heating, ventilating, and air conditioning vents through the quality assurance process The Maintenance Director will monitor all vent covers in the building monthly to mak sure they are properly hung. Findings will	s. e be
SS=D	8/17/10 at 9:38 AM, cover was hanging Protection Associated Protection Associated Administrator and volume Administrator	peauty shop storage room on revealed the exhaust fan vent down. National Fire on (NFPA) 90A knowledge by the erified by the Director of exit conference on 8/17/10. FETY CODE STANDARD or smoking signs in areas ed or stored are in accordance A 99, 8.6.4.2. Inot met as evidenced by: on it was determined the tain the no smoking signs.	K 14	reported to the Quality Assurance Committed which is made up of the following people: Medical Director, Administrator, Director of Nursing, Health Information Manager, Social Services Director, Falls Prevention Nurse, Facility Rehab Coordinator and Wound Can Nurse. The monitor will be continued as determined by the Maintenance Director or as directed by the Quality Assurance Committee. K 141 No smoking signs On 8-18-10 the administrator placed a no smoking sign on the hydro therapy bathroom On 9-2-10 the maintenance director review all areas of the building to determine if proper signage in place. On 9-6-10 the Administrator inserviced all staff on making sure no smoking signs are in place where oxygen is being stored. Completed 9-6-10 The Maintenance Director will monitor compliance of smoking signs through the quality assurance process. The Maintenance Director will monitor all areas of the building monthly x 3 months to evaluate smoking signs are in place.	of ial re 9-6-10 n. ed

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		& MEDIC/ SERVICES					. 0938-0391
CENTERS FOR MEDICARE & MEDIC/ SERVICES STATEMENT OF DEFICIENCIES (X1) PROVIDE SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01			(X3) DATE SURVEY COMPLETED		
		445130	B. WIN	G		08/1	7/2010
	ROVIDER OR SUPPLIER ALTHCARE, SPARTA			34	ET ADDRESS, CITY, STATE, ZIP CODE GRACEY ST ARTA, TN 38583		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG		PROVIDER'S PLAN OF CORRE (EACH CORRECTIVE ACTION SH CROSS-REFERENCED TO THE APP DEFICIENCY)	OULD BE	(X5) COMPLETION DATE
K 147 SS=E	8/17/10 at 9:25 AM room and no preca Fire Protection Ass This findings was a Administrator and was Maintenance at the NFPA 101 LIFE SA Electrical wiring and with NFPA 70, National Fire Protection of the 8/17/10 at 9:35 AM National Fire Protection of the at 10:20 AM, revea blocked with equipart These finding were Administrator and was a size of the second se	revealed oxygen stored in the utionary sign posted. National ociation (NFPA) 99, 8.6.4.2 cknowledged by the rerified by the Director of exit conference on 8/17/10. FETY CODE STANDARD dequipment is in accordance ional Electrical Code. 9.1.2 s not met as evidenced by: ion it was determined the ntain the electrical system.	K 1	147	F 141 cont. Findings will be reported to the of Assurance Committee which is make the following people: Medical Discourse Administrator, Director of Nursin Information Manager, Social Ser Director, Falls Prevention Nurse, Rehab Coordinator and Wound Committee Wiring and Equation 10 the Information Maintenance Shop we of all items stored in front of them. 10 the Maintenance Director review areas in the building to verify that in light covers were broken and that a electrical panels were free from bein blocked. On 9-6-10 the Administrationserviced all staff on making sure the broken items are reported to maintenand making sure that all electrical premain unblocked. Completed 9-6-10 The Maintenance Director will more compliance of electrical wiring and equipment through the quality assurprocess. The Maintenance Director monitor all areas of the building more months for broken light covers and lelectrical panels and correct immediated found. Findings will be reported to Quality Assurance Committee which up of the following people: Medical Administrator, Director of Nursing, Information Manager, Social Service 10 to 10	rector, ng, Health vices , Facility Care Nurse. sipment dean linen detectrical dere cleared On 9-2- wed all no other lil ng tor that denance denance will mithly x 3 blocked diately if the h is made Director, Health des	9-6-10
					Administrator, Director of Nursing,	Health es cility	

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The monitor will be continued as determined by the Maintenance Director or as directed by the Quality Assurance Committee.